



The Centers for Medicare and Medicaid Services:  
SUPPORT Act Section 1003 Grant



## SUD Technical Assistance Webinar Series



# VIRGINIA MEDICAID: 25— ASAM CRITERIA ASSESSMENT DIMENSION 4 PAUL BRASLER, LCSW APRIL 19 & 20, 2021

*Department of Medical Assistance Services*

# Welcome and Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact [SUD@dmass.virginia.gov](mailto:SUD@dmass.virginia.gov) with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – [www.dmass.virginia.gov/#/ARTS](http://www.dmass.virginia.gov/#/ARTS)
- We are unable to offer CEUs for this webinar series

# Copyright

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- ▶ **Last revision: April 6, 2021**

# CSM Disclaimer

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

# SUPPORT Team Disclaimer

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- ▶ The ASAM dimensions are designed to guide the assessment process and ensure that each client receives the most appropriate, individualized treatment. A clear understanding of these treatment assessment dimensions is critical for providers, Managed Care Organizations and other professionals in order to operationalize this content in practice with Medicaid members who have a substance use disorder
- ▶ **PLEASE NOTE** that the goal of this training is to help raise providers' awareness and understanding around implementing ASAM Treatment Assessment dimensions. This training is not designed as a substitute for official ASAM training, nor is this to serve as a substitute for any ASAM training that is required by any local, state, or federal regulatory agency or certifying organization. **This training is not sponsored or endorsed by ASAM**

# Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

**If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.**

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a \$50 Amazon gift card as well as participation in the post-webinar survey will enter you into another \$50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at [Lori.keysermarcus@vcuhealth.org](mailto:Lori.keysermarcus@vcuhealth.org) or (804) 828-4164. Thank you for helping us with this effort!



# Naloxone Resources

- ▶ Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - <http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training>
  - <https://getnaloxonenow.org/>
    - Register and enter your zip code to access free online training
- ▶ Medicaid provides naloxone to members at no cost and without prior authorization!
- ▶ Call your pharmacy before you go to pick it up!
- ▶ Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - <https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422>
  - Available only to Virginia residents, intramuscular administration

# SUPPORT Act Grant Website -

<https://www.dmas.virginia.gov/#/artssupport>

## SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

### Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

### Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

### Period of Performance

September 2019 - September 2021

### Grant Email

[SUPPORTgrant@dmas.virginia.gov](mailto:SUPPORTgrant@dmas.virginia.gov)

### Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

### Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

### Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

### Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

### SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]



# Hamilton Relay Transcriber (CC)

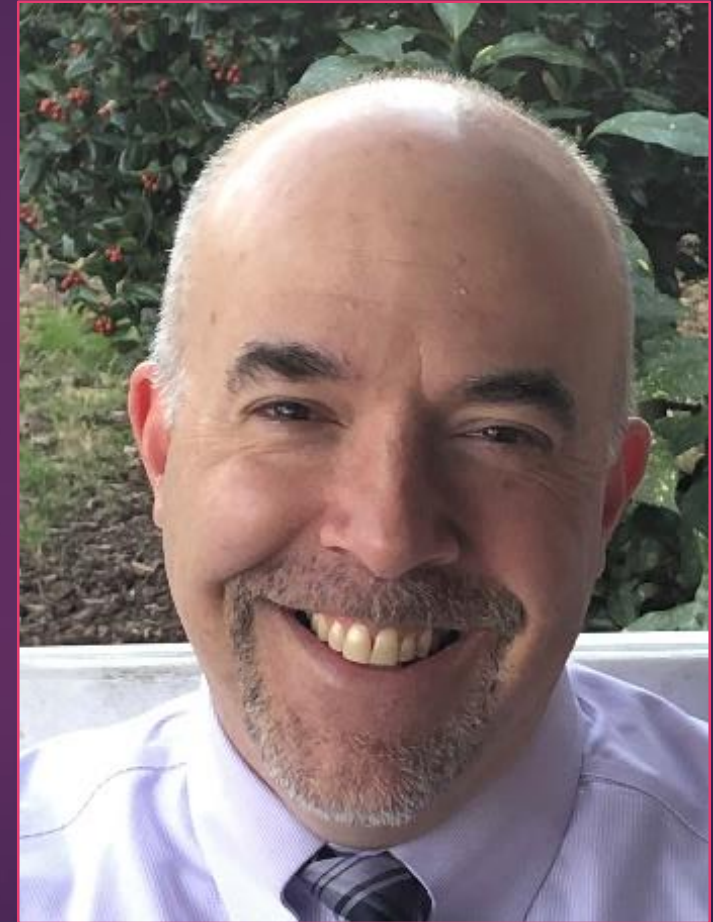
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- ▶ The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- ▶ We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- ▶ The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

# Today's Presenter

Paul Brasler, MA, MSW, LCSW  
Behavioral Health Addiction Specialist, DMAS

Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.



# Contact Information

Paul Brasler:

[Paul.Brasler@dmas.virginia.gov](mailto:Paul.Brasler@dmas.virginia.gov)

SUPPORT Act Grant Questions:

[SUPPORTGrant@dmas.virginia.gov](mailto:SUPPORTGrant@dmas.virginia.gov)

ARTS Billing Questions

[SUD@dmas.Virginia.gov](mailto:SUD@dmas.Virginia.gov)

# First Things First...

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- ▶ Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider
- ▶ Prior to even thinking about doing an assessment, we need to agree:
  - ▶ People are worthy of help, have the right to self-determination, and should be treated with respect and dignity
  - ▶ Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about
  - ▶ No one sets out to become addicted to substances or behaviors
  - ▶ Recovery is possible and is defined by the client

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# Language

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- ▶ We want to use “Person-Centered language”
  - ▶ Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
  - ▶ Not “Addiction,” but **Substance Use Disorder (SUD)**
  - ▶ Not “Abuse,” but **Use**
  - ▶ Not “Clean,” but **In Recovery** or **Testing Negative**
  - ▶ Not “Dirty,” but **Testing Positive**
  - ▶ Not “Relapse,” but **Return to Use**
- ▶ At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms
- ▶ Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)



# A Brief Word on SUD Treatment

People with SUD may engage and dis-engage in treatment during their illness; knowledge gained during treatment can be cumulative, therefore this back-and-forth pattern should not be viewed as treatment failure

“Across all diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition* [DSM-5], fewer than 25% of persons with addictive disorders enter professional treatment in their lifetimes. With smoking, the deadliest of addiction, fewer than 10% ever participate in a professional treatment program.”

(Herron & Brennan, 2020, p. 356)



# Why ASAM (American Society of Addiction Medicine) Criteria?

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*“The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* has its roots in the mid-1980s and was designed to help clinicians, payers, and regulators use and fund levels of care in a person-centered and individualized treatment manner. To increase access to care and improve the cost-effectiveness of addiction treatment, the ASAM Criteria represents a shift from [italics in original]:

(con’t)

# Why ASAM (American Society of Addiction Medicine) Criteria?

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- ▶ One-dimensional to multidimensional assessment—from treatment based solely on diagnosis to treatment that addresses multiple needs
- ▶ Program-driven to clinically and outcome-driven treatment—from placement in a program often with fixed lengths of stay to person-centered, recovery-oriented, individualized treatment response to specific needs and progress and outcomes in treatment
- ▶ Fixed length of service to a variable length of service, based on patient needs and outcomes; and
- ▶ A limited number of discrete levels of care to a broad and flexible continuum of care in a chronic disease management system of care” (Herron & Brennan, 2020, p. 172)

# ASAM Criteria Levels of Care

Level of Care	Description (Herron & Brennan, 2020, pgs. 174 – 175)
4.0	<b>Medically managed intensive inpatient.</b> 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage patient in treatment
3.7	<b>Medically monitored intensive inpatient.</b> 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours per day for counselor availability
3.5	<b>Clinically managed high-intensity residential treatment.</b> 24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment; able to tolerate and use a full active milieu or therapeutic community
3.3	<b>Clinically managed-population-specific high-intensity residential.</b> 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community
3.1	<b>Clinically managed low-intensity residential.</b> 24-hour structure with available trained personnel with emphasis on re-entry to the community; at least 5 hours of clinical service per week
2.5	<b>Partial Hospitalization.</b> 20 hours of service or more per week in a structured program for multi-dimensional instability not requiring 24-hour care
2.1	<b>Intensive Outpatient.</b> 9 hours of service or more per week (adults); 6 hours or more per week (adolescents) in a structured program to treat multi-dimensional instability
1.0	<b>Outpatient Services.</b> Less than 9 hours of service per week (adults); <6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies

# ASAM Criteria Assessment Dimensions

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- ▶ ASAM exists to provide best-practices guidance for SUD providers in all treatment settings
  - ▶ This includes guidance on how to conduct a comprehensive assessment for all clients receiving SUD treatment

**There is not a specific ASAM Assessment form or template**

- ▶ Instead ASAM outlines **six criteria dimensions** that should be a part of every SUD assessment to ensure that the client's needs are identified and met

# ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
1. Acute intoxication and/or withdrawal potential	Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical conditions and complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services

# ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
3. Emotional, behavioral, or cognitive conditions and complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
<b>4. Readiness to change</b>	<b>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</b>



# ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
5. Relapse, continued use, or continued problem potential	Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies
6. Recovery environment	Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas



Comprehensive assessment of the patient is critical for treatment planning



However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder



If not completed before initiating treatment, assessments should be completed soon thereafter

# ASAM Assessment Recommendations (ASAM, 2020, p. 26)

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# Assessment Criteria

## Dimension 4

**READINESS TO CHANGE**

# Assessment Criteria Dimension 4

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- ▶ Assess stage of readiness to change
- ▶ If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies
- ▶ If ready for recovery, consolidate and expand action for change

# Recommendation

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- ▶ Time constraints limit how much information I can provide in this single training
- ▶ To fully understand this criteria dimension, I recommend you also view the following webinars (which can be found on our website):
  - ▶ 3 Suicide
  - ▶ 6 Trauma-Informed Care
  - ▶ 11 Co-Occurring Disorders

# Assessment Overview

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- ▶ All clients should receive a comprehensive behavioral health assessment as part of the treatment process, regardless of the service setting
- ▶ Assessing clients includes **four primary areas** (plus an additional two areas if time permits) of focus:
  - A. **Suicide/Lethality Assessment**
  - B. **Substance Use Assessment**
  - C. **Mental Status Exam**
  - D. **Basic Trauma Assessment**
  - E. Medical & Mental Health History
  - F. Family & Social History



# Connecting During the Assessment

People usually want to talk and tell their story, so give them that chance:

- ▶ **“Why are you here?”** “What’s going on?” “What do you hope to get out of coming here?”
- ▶ “How long has this been a problem?”
- ▶ “Has anything helped in the past?”
- ▶ “Why are you looking for help now?”

Ask simple opening questions and then provide time for the client to talk with as few interruptions as possible

# Substance Use Assessment

(Brasler, 2019)

- A. Substances** used (including tobacco, alcohol and caffeine) ["Tell me about your drug use"]
- B. Last use** (for each drug) ["When did you last use?"]
- C. Current drug** use ["What is your drug use like during an average week?"]
- D. Routes** of use (for each substance)
- E. Durations** of use (for each substance) ["How long have you been using?"]
- F. Amounts** of use (for each substance) ["How much do you use?"]

# Substance Use Assessment

(Brasler, 2019)

- G. Tolerance** (having to use more of a chemical to get the same reaction as before)
- H. Withdrawal** symptoms
- I. Impact** on education, job, relationships, health, legal problems
- J. Past treatment**; periods of sobriety or recovery
- K. Motivation** for treatment
- L. Family history** of substance use

# Why Motivational Interviewing: The Historical Context

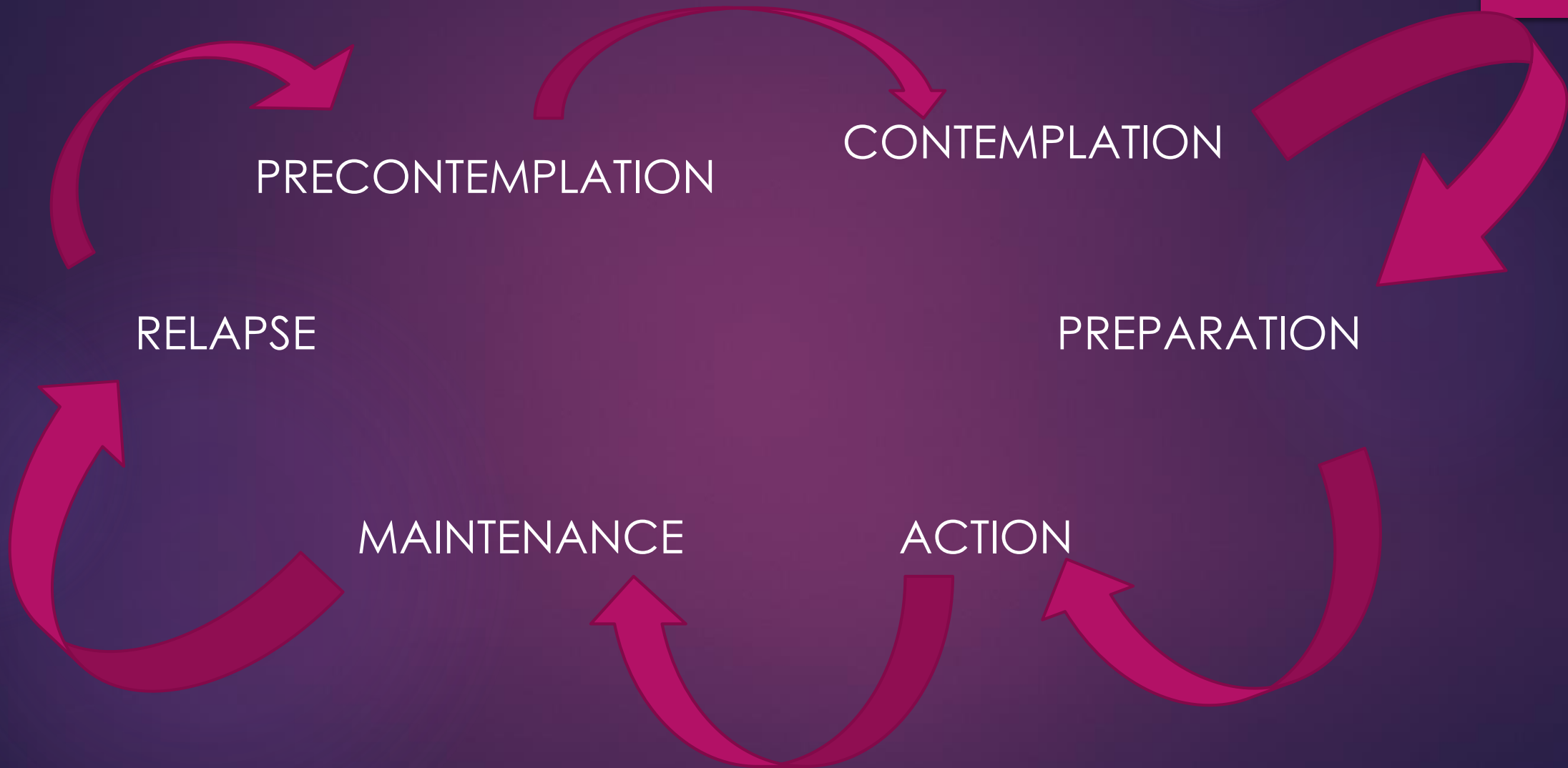
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# Stages of Change Model

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# Stages of Change Model

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## Precontemplation

- The person may be unaware of any reasons for changing behavior: “Problem? What problem?”
- May resist being told what to do
- May have rationalized why they do not think they need to change
- “Typically underestimate the benefits of change and overestimate the costs” (Herron & Brennan, 2020, p. 354)
- Or they may feel hopeless about ever changing and have therefore given up any desire to change
- May need the opportunity to learn and reflect on their behavior’s impact on their life



# Stages of Change Model

## Contemplation

- ▶ The person recognizes that there is a problem...
- ▶ ...but they are either ambivalent about making any changes or are not committed to changing at the present time
- ▶ People in this stage are usually more open to collecting information about the behavior and weighing the pros and cons of changing or not changing
- ▶ Remember that just because a person has an interest in changing does not mean that they are ready to do so

DECISION BALANCE	Make the Change	Don't Change
PROS		
CONS		



# Stages of Change Model

## Preparation

- ▶ The person has accepted the idea of making changes and begins to look at ways to make the changes
- ▶ This could involve attempts to decrease the amount of use, or setting a date to stop using
- ▶ The person may begin to change (or make attempts to change) other things in their life that could support the main change

# Stages of Change Model

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## Action

- ▶ Taking a definitive step such as entering treatment (including working a 12-step program, and not just attending group)

## Maintenance

- ▶ Acknowledging that lapses can occur and continuously developing strategies to address potential lapses (e.g., Serving as a sponsor, etc.)



# Relapses Happen

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- ▶ **Relapse** is defined as a return to regular use after a period of sobriety; **lapses** are sometimes differentiated as a single period of use without a return to regular use
- ▶ A goal of SUD treatment is to anticipate relapses, and develop ways to both avoid them AND deal with them if they happen
- ▶ Expect relapses to happen, and do not judge the client for this and reframe them as opportunities for continued growth in treatment
- ▶ Be sure to re-assess the client following a relapse to determine if they require prompt medical attention
- ▶ Help clients recognize relapse warning signs/triggers

# Motivational Interviewing

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## **Resistance is to be expected and is a key concept of MI**

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- ▶ Rolling with resistance is one of the hallmarks of MI
- ▶ Instead of confronting the client's resistance outright, the resistance is reframed:

*Client: How are you supposed to help me?*

*Social Worker: You are concerned about my qualifications in being able to help you? That is okay. I am glad that you are thinking about how I can help you*





Identify target behavior



Reduce resistance to change/treatment



Build desire to change (increase its perceived importance)



Build confidence to change



Elicit a commitment/plan to change

# Tasks of Motivational Interviewing (Smout, 2008, p. 7)

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# How Can More People with SUD be Motivated to Seek Help?

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By changing paradigms: (Herron & Brennan, 2020, p. 356)

1. The first is an action-oriented paradigm that construes behavior change as an event that can occur quickly, immediately, discretely, and dramatically. Treatment programs that are designed to have patients immediately quit [using] substances are implicitly or explicitly designed for the portion of the population in the preparation stage. The problem is that with most unhealthy behaviors, fewer than 20% of the affected population is prepared to take action
2. The second is to move from a passive-reactive approach to a proactive approach. Most professionals have been trained to be passive-reactive: To passively wait for patients to seek their services and then to react

# Principles of Change (Herron & Brennan, 2020, pgs. 356 – 357)

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1. The benefits for changing must increase if patients are to progress beyond precontemplation  
(Suggestion: Challenge clients to identify as many positive reasons for making a change)
2. The “cons” of changing must decrease if patients are to progress from contemplation to action
3. The relative weight assigned to benefits and costs must cross over before a patient will be prepared to take action

# Principles of Change (Herron & Brennan, 2020, pgs. 356 – 357)

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4. The strong principle of progress holds that to progress from precontemplation to effective action, the rewards for changing must increase
5. The weak principle of progress holds that to progress from contemplation to effective action, the perceived costs of changing must decrease
6. It is important to match particular processes of change with specific stages of change

# Motivational Interviewing Keys

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- ▶ Client-centered (**the client is the expert**), directive therapy, originally developed to treat SUD; now used to treat a variety of issues
- ▶ The counselor's style and ability to connect with the client are key
- ▶ MI explores and resolves the client's ambivalence by focusing on collaboration
- ▶ Uses ideas and backgrounds from a variety of theories, but grew out of a distaste of older, confrontational models
- ▶ Based on:
  - ▶ Carl Rogers and unconditional positive regard
  - ▶ Cognitive Dissonance (current behaviors vs. future goals)

## O: Open-ended Questions

- “How can I help you with \_\_\_\_\_?”
- “Help me understand \_\_\_\_\_?”
- “How would you like things to be different?”
- “What have you tried to do before to make a change?”
- “What do you want to do next?”

## A: Affirmations

- “You handled yourself very well in that situation”
- “I have enjoyed talking with you today”
- “That is a good suggestion”
- “You clearly have a lot of strengths”

# MI Technique: OARS



## R: Reflective Listening

- “So you feel....”
- “It sounds like you....”

## S: Summarizing

- “Let me see if I understand so far...”
- “Here’s what I’ve heard. Tell me if I’ve missed anything”
- *Pay special attention to change statements:*
  - “My use has gotten out of hand at times”
  - “If I don’t stop, something bad is going to happen”
  - “I’m going to do something, I’m just not sure yet”

# MI Technique: OARS

# MI Processes (Herron & Brennan, 2020, pgs. 357 – 358)

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- ▶ Consciousness Raising (Get the Facts)
- ▶ Dramatic Relief (Pay Attention to Feelings)
- ▶ Environmental Reevaluation (Notice Your Effect on Others)
- ▶ Self-Reevaluation (Create a New Self-Image)
- ▶ Self-Liberation (Make a Commitment)
- ▶ Counterconditioning (Use Substitutes)
- ▶ Reinforcement Management (Use Rewards)
- ▶ Stimulus Control (Manage Your Environment)
- ▶ Helping Relationships (Get Support)
- ▶ Social Liberation (Notice the Public Effort)

# MI Processes (Herron & Brennan, 2020, pgs. 357 – 358)

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- ▶ **Consciousness Raising** involves increased awareness of the causes, consequences, and responses to a particular problem.
  - ▶ Provide personal feedback about the current and long-term consequences of continuing the addictive behavior
- ▶ **Dramatic Relief** involves emotional arousal about one's current behavior and the relief that can come from changing
  - ▶ Psychodrama, role-playing, grieving, and personal testimonies are examples of techniques that can move people emotionally
  - ▶ It should be noted that earlier literature on behavior change concluded that interventions such as education and fear arousal did not motivate behavior change
- ▶ ***These processes are designed to move people to contemplation***

# MI Processes (Herron & Brennan, 2020, pgs. 357 – 358)

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- ▶ **Environmental Reevaluation** combines both affective and cognitive assessments of how an addition affects one's social environment and how changing would affect the environment
- ▶ **Self-Reevaluation** combines both cognitive and affective assessments of an image of one's self free from addition
  - ▶ Imagery, healthier role models, and values clarification are techniques used here
- ▶ **Self-Liberation** involves both the belief that one can change and the commitment and recommitment to act on that belief
  - ▶ Motivational research also suggests that individuals who have only one choice are not as motivated as those who have two choices

# MI Processes (Herron & Brennan, 2020, pgs. 357 – 358)

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- ▶ **Counterconditioning** requires the learning of healthier behaviors that can substitute for addictive behaviors
  - ▶ Desensitization, assertion, and cognitive counters to irrational self-statements
- ▶ **Reinforcement Management** involves the systemic use of reinforcements and punishments for taking steps in a particular direction
  - ▶ Contingency contracts, overt and covert reinforcements, and group recognition are methods of increasing reinforcement and incentives that increase the probability that healthier responses will be repeated
  - ▶ Clients should be taught to rely on self-reinforcements than on social reinforcements



# MI Processes (Herron & Brennan, 2020, pgs. 357 – 358)

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- ▶ **Stimulus Control** involves modifying the environment to increase cues that prompt healthy responses and decrease cues that lead to relapse
  - ▶ Avoidance, removing addicting substances and paraphernalia, attending peer-recovery groups
- ▶ **Helping Relationships** combine caring, openness, trust, and acceptance as well as support for changing
  - ▶ Rapport building, a therapeutic alliance, counselor calls, peer recovery specialists, peer support groups
- ▶ **Social Liberation** is the process by which changes in society increase the options and opportunities to have healthier and happier lives



# More MI Strategies & Techniques

- ▶ Change talk; optimism to change
- ▶ Normalizing
- ▶ Columbo approach
- ▶ Supporting self-confidence
- ▶ Readiness to change scale
- ▶ Giving advice
- ▶ Therapeutic paradox: “What if you kept doing what you are doing?”

# Terminating Clients

“There is no other major health problem for which one is admitted for professional care and then punitively discharged from treatment for becoming symptomatic in the service setting. For other healthcare problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment and alternative approaches to patient education and motivation are needed” (White, 2014, p. 519)

**Continued use of substances  
may indicate a need for a  
higher level of care, and should  
NOT be used as a reason to  
terminate treatment**

In my opinion there are only a few reasons to terminate a client, specifically:

1. Violence, or threatened violence, (and this could include verbal threats) toward peers and/or staff
2. Distributing illicit substances on clinic property

# Terminating Clients

# References

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